Patient Name: _____

Fox Valley Orthodontics Current Medication List

Are you taking any prescription medications, over the counter medications, vitamins, natural, herbal and/or dietary supplements?

YES _____ NO _____

DATE: _____

Please list all medications:	*Reason taking:*	*How much:*	*How often:*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			

Signature: _____